Norfolk Safeguarding Adults Board

Safeguarding Adults Review:

Douglas

Executive Summary

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1. Introduction

1.1. Douglas was 21 years old when he tragically took his own life in July 2022. Throughout his life he lived with neurodiversity, multiple physical and mental health conditions, and significant caring responsibilities within his family. His experiences brought him into contact with a range of services across both children's and adults' systems. In recognition of the complexity of his circumstances and the need to understand what could be learned from his life and death, the Norfolk Safeguarding Adults Board commissioned a Safeguarding Adult Review (SAR) under Section 44(4) of the Care Act (2014).

1.2. The purpose of this SAR is to identify what agencies and individuals might have done differently to reduce the risk of harm, and to ensure that learning is applied to strengthen future practice. It is not a process for attributing blame. The review focuses on understanding Douglas's lived experience, how well agencies recognised and responded to his needs, and the effectiveness of multi-agency working during the transition from childhood to adulthood.

1.3. The review was undertaken by an independent reviewer working alongside a multi-agency SAR panel. It draws on a wide range of information, including agency chronologies and reports, practitioner reflections, and extensive contributions from Douglas's family, whose insight and commitment to improving outcomes for others has been invaluable. Although three years have passed since Douglas's death, agencies have already begun implementing early learning, and this review builds on that progress by identifying the areas where practice still requires strengthening.

2. Methodology and timeframe

2.1 The review was overseen by a multi-agency SAR panel comprising senior representatives from key partner organisations. All panel members were independent of the services directly involved with Douglas and his family. The Terms of Reference established four key lines of enquiry:

1. Whether the needs of the family were considered holistically in planning and assessment.

2. The extent to which Douglas's lived experience was understood and used to shape the support he received.

3. The effectiveness of transitional safeguarding and preparation for adulthood in Douglas's case.

4. How well agencies recognised and responded to the impact of Douglas's caring responsibilities.

Multi-agency working was examined as a golden thread across all lines of enquiry.

2.2 Although SARs typically focus on recent practice, the partnership agreed that learning relating to Douglas's transition from children to adults' services was essential. The review therefore considered the period **1 November 2017 to 2 July 2022**, with earlier relevant information included where necessary to understand context and decision-making.

3. Context

3.1 Douglas was born in 2000 and lived in Norfolk throughout his life with his parents, Charlie and Peter, and his younger sister, Henrietta. Following his parents' separation when he was around ten, Douglas and his sister initially lived between both homes before later spending most of their time with their mother to support easier access to education and health services.

3.2 The family lived with significant and complex vulnerabilities. Douglas had multiple long-term health conditions, including Familial Adenomatous Polyposis, which led to major surgery in 2017, Autistic Spectrum Disorder, anxiety with psychotic symptoms, chronic depression, and Coeliac Disease. He also held caring responsibilities for his sister and, at times, his mother. Henrietta had a rare genetic chromosome abnormality resulting in global developmental delay, a learning disability, and behaviours that were often physically and verbally aggressive. Charlie also lived with Familial Adenomatous Polyposis, severe chronic fatigue, and mental health pressures linked to the family's circumstances.

3.3 The cumulative impact of these needs created a highly pressured home environment, with numerous professionals involved and Charlie feeling like she constantly had to fight for support. Despite these challenges, Douglas had many strengths and interests. He was an avid reader of classic literature, passionate about history and politics, and had begun studying American Studies at university. He enjoyed gaming and built online friendships, which his parents felt were easier for him to navigate given his social communication difficulties. He travelled widely, rode motorcycles with his father, and loved animals, particularly sloths and gerbils.

3.4 Douglas also experienced periods of significant distress. Severe anxiety was a recurring theme, he had been prescribed various antidepressants since 2017, but he was not taking medication at the time of his death. Douglas had ongoing suicidal thoughts from his early teens but repeatedly told professionals he had no intention of acting on them. However, despite these assurances he made two attempts to take his life in 2019 and died following a further attempt in 2022, three weeks before his 22nd birthday. The inconsistencies between what Douglas communicated and his subsequent actions may relate to social communication difficulties associated with autism.

3.5 Douglas was known to a wide range of agencies across health, local authority, education, and the voluntary sector. However, despite his own significant needs, he was never open to Children's Services or Adult Social Services in his own right – a gap in practice explored within the report.

4 Analysis and Learning

Key Line of Enquiry 1 - Were the needs of the family considered in their entirety, including in all planning and assessments?

4.1 Following the separation of his parents, Douglas spent a considerable portion of his life living across two households (his mother's and father's), towards the latter stages of this review the majority of time was spent at his mother's house. Within the mother's household, each person (Douglas, Henrietta, and Charlie) had a range of professionals working with them on an individual level and collectively across all three people. The network of professionals supporting the household unit was immense and this placed a great deal of pressure on this household. Despite the significant and interconnected needs within the family, the review found that agencies did not consider the household as a whole. While Henrietta received substantial support, including assistive technology, consistent Preparing for Adult Life (PfAL) involvement, and access to groups she enjoyed, there was limited evidence that professionals assessed or responded to the combined pressures affecting the wider family unit.

4.2 Charlie lived with chronic health conditions and severe fatigue while caring for two children with complex needs: Henrietta, whose learning disability manifested in behaviours which could be physically and verbally aggressive, and Douglas, who was neurodivergent, anxious, and at times self-harming. Charlie described feeling overwhelmed, constantly fighting for services, and managing an unmanageable number of professionals. Although some respite was available for Henrietta, it was limited, and the cumulative stress within the household was not sufficiently recognised or addressed.

4.3 This pressure intensified in June 2022 when a decision to defer funding for Henrietta's permanent residential placement left the family at "breaking point," as highlighted by the PfAL worker. While the review does not conclude that this decision directly contributed to Douglas's death, it undoubtedly added significant strain to an already fragile situation.

4.4 There were isolated examples of a whole-family approach, such as behavioural family therapy offered in 2018, but these were exceptions rather than embedded practice. More broadly, agencies tended to work with individual family members rather than understanding the household as an interconnected system.

4.5 Charlie also reported being given leaflets and information without explanation, leaving her confused about available support. For families managing neurodiversity, high stress, and multiple professionals, written materials alone are insufficient. Relational communication – clear, guided, and personalised – is essential.

4.6 The review highlights the need for a dedicated liaison role for families with complex, multi-agency involvement. Models such as family liaison officers, exploitation-specific parent support roles, and Norfolk's Transforming Care Navigators demonstrate the value of consistent, trusted professionals who help families navigate systems, understand processes, and access support.
For families like Douglas's, identifying such a professional – based on existing trusted relationships – would provide continuity, reduce confusion, and strengthen multi-agency coordination.

Engaging Fathers and Male Carers

4.7 The review found that Douglas's father, Peter, was largely absent from assessments, planning, and agency involvement despite being an active and consistent presence in his children's lives. Information was predominantly gathered from Douglas's mother, and concerns she raised about Peter were accepted at face value without verification. As a result, practitioners overlooked a key source of insight and potential support, creating significant gaps in understanding risk and family dynamics. This reflects a wider pattern in which fathers and male carers are insufficiently engaged, particularly when parental relationships are acrimonious. Although Norfolk has strengthened father-inclusive practice in recent years, this case highlights the continued need for practitioners to involve fathers proactively, seek their views directly, and apply professional curiosity rather than relying on one parent's account.

Key Line of Enquiry 2 - What was Douglas's lived experience and did agencies fully understand it? How was Douglas's lived experience used to influence the services and support he received?

4.8 Douglas spent most of the review period living with his mother and sister, acting as the primary carer for Henrietta, whose complex needs and challenging behaviours placed significant emotional and physical strain on him. While agency records contain extensive information about Henrietta and Charlie's view on services, there is comparatively little evidence of Douglas's own voice, or the support offered to him. Although some GP, hospital and education records reflect his lived experience and prompted appropriate action, this was not consistent across the partnership. Douglas often masked his distress, sought to please others, and presented a more positive picture of his circumstances than he may have experienced, telling professionals he "*didn't want to be a burden*." As a result, agencies did not develop a full understanding of his day-to-day reality, which limited their ability to tailor support effectively. The review focused on three key aspects of Douglas's experience: autism and self-identity, mental health, and how well his voice was heard.

Autism, Self-Identity and Understanding Lived Experience

4.9 Douglas's experience of autism was a central but insufficiently understood aspect of his life. Developing a sense of identity is challenging for many young adults, but for Douglas – who was autistic, a young carer, a student – this process was particularly complex. Although he received a formal Autism Spectrum Disorder (ASD) diagnosis at 17 following a privately funded assessment, there is limited evidence that agencies explored what this diagnosis meant to him, how he understood his autism, or how it shaped his daily life. Records suggest he may not have fully accepted the diagnosis, which may have influenced his engagement with support.

4.10 There were examples of good practice: his further education provider secured an Education, Health and Care Plan (EHCP), adapted his timetable, and offered pastoral support; his university made reasonable adjustments and ensured wellbeing input; and he benefited from continuity with the same GP. However, these positive examples were not replicated across the wider partnership. Many agencies simply noted his diagnosis without demonstrating understanding of his needs, communication style, or the impact of autism on his mental health, identity, or help-seeking behaviour. As a result, a significant part of Douglas's lived experience remained unknown.

4.11 Douglas was eligible for both a children's social care assessment at 17 and an adult social care assessment at 18, but neither took place. These were missed opportunities to understand his needs, provide tailored support, and relieve pressure on the wider family. Practitioners also reported that, at the time, autism awareness across the partnership was limited, with work often framed through mental health or learning disability rather than autism in its own right.

Autism and mental health

4.12 Autistic people experience significantly higher rates of mental health difficulties, with anxiety and depression affecting the majority, and research showing markedly increased risks of suicidal thoughts and attempts compared with the general population. These vulnerabilities are often compounded by barriers to accessing effective mental health care, including difficulties expressing feelings and services that are not always adapted to autistic communication styles.

4.13 Douglas lived with long-standing mental health challenges, including depression, anxiety with psychotic symptoms, and self-harm. He had a history of suicidal thoughts and made two attempts in 2019 before his death in 2022. Across multiple contacts with health services, he consistently reassured practitioners that he had no intention of acting on these thoughts and had coping mechanisms in place. Practitioners accepted these accounts, and there is limited evidence that his suicidal ideation was explored through the lens of autism, despite his tendency to mask distress, avoid burdening others, and present a more positive picture of his circumstances.

4.14 Traditional suicide-risk assessments rely heavily on verbal self-reporting, which can be particularly challenging for autistic individuals who may interpret questions literally, struggle to articulate internal states, or provide socially expected answers. This case highlights the need for practitioners – especially in acute settings – to recognise the elevated suicide risk among autistic people and to adapt assessment approaches accordingly, including clearer language, tailored questions, and greater reliance on behavioural indicators and collateral information.

4.15 National and local policy developments reflect growing recognition of these issues. The Norfolk and Waveney Suicide Prevention Strategy identifies autistic people as a priority group, and the Zero Suicide Alliance has developed autism-specific training now being promoted through the Norfolk Autism Partnership. This review reinforces the importance of such initiatives and the need for continued system-wide improvement in understanding, identifying, and responding to the mental health needs of autistic adults.

Hearing Douglas's Voice

4.16 At the start of the review period Douglas was 17 and legally still a child, yet his voice was not consistently heard or prioritised. While the Children Act 1989 requires professionals to give due weight to a child's views, parental voices – particularly in high-need families – can dominate professional attention. In Douglas's case, his own wishes and feelings are largely absent from agency records.

4.17 Charlie was a strong advocate for her children and communicated frequently with services, often out of fear and frustration at the difficulty securing support. However, her persistence was at times misinterpreted as challenging behaviour rather than a trauma-informed response to overwhelming circumstances. This dynamic contributed to professionals relying heavily on her perspective, while Douglas's own voice became increasingly obscured.

4.18 Practitioners reported that Charlie often spoke on Douglas's behalf, and opportunities to hear directly from him were limited. Douglas engaged best in 1:1 setting, where he was more able to express how he felt, but many services had shifted towards group-based models that did not meet his needs. As a result, agencies did not develop a clear understanding of his lived experience – either as a child or as an adult – and this represents a significant gap in practice.

4.19 The review highlights the need for practitioners to ensure that every individual's voice is heard within complex families, to avoid assumptions based on parental accounts alone, and to offer support in formats – such as 1:1 sessions – that enable young people like Douglas to communicate openly.

Key Line of Enquiry 3 - What role did transitional safeguarding/preparing for adulthood play for Douglas and how effective was it?

Transitional Safeguarding

4.20 Children's and adults' services operate with different eligibility criteria and safeguarding frameworks: children's services focus on welfare and protection, while adults' services emphasise capacity and risk enablement. As a result, many young people experience a "cliff edge" at 18, losing access to support at the point they may need it most. Transitional safeguarding offers a more fluid, developmentally-attuned approach that bridges adolescence and adulthood, recognising that transition is a journey rather than a single event and requires coordinated, system-wide practice.

4.21 Despite Douglas's significant vulnerabilities – including complex health needs and his role as a young carer – he was never open to children's social care in his own right. Although his sister received support through Early Help and the Children with Disabilities service, no concerns were raised about Douglas, and he did not receive an assessment. Consequently, there was no transition into adult social care, and he remained entirely outside adult services.
This represents a major gap in practice.

4.22 Although transitional safeguarding did not apply directly in Douglas's case, Norfolk has already taken steps to strengthen this area. In 2023, the Norfolk Safeguarding Adults Board and Norfolk Safeguarding Children Partnership jointly commissioned a scrutiny review to examine current arrangements, identify good practice, and learn from national models. The review found variability across the county and made recommendations now being taken forward through an agreed action plan.

Mental Health and Transitions

4.23 Douglas's transition between child and adult mental health services was minimal because his first significant contact with mental health services occurred shortly before his 18th birthday. He received early intervention support for nine months, including family therapy, and was discharged as an adult with reported improvements. He then had no further mental health contact for almost a year.

4.24 Shortly after starting university, Douglas experienced a sharp escalation in anxiety and suicidal ideation. Although his GP made an urgent referral, this was downgraded, and no immediate contact was made. Before the scheduled appointment, Douglas presented twice to A&E following suicide attempts. Despite these incidents, he did not meet the threshold for Early Intervention support and was referred to the Youth Team – where he remained on a waiting list for eight months without contact. When support finally began, it was disrupted again when his care coordinator left, resulting in a further two-month wait.

4.25 This sequence created a critical gap in support at a time of acute vulnerability. Douglas's anxiety increased significantly during this period of uncertainty, and this was likely exacerbated by his autism, which made waiting, ambiguity, and lack of communication particularly difficult.

4.26 Douglas also chose not to involve his family in his mental health care while at university, and although this decision was respected, there is limited evidence that practitioners explored whether another trusted adult could be identified. National guidance published since his death emphasises the importance of involving trusted contacts – familial or otherwise – in suicide prevention for students.

4.27 This case highlights two key areas of learning: the need for autism-informed suicide-risk assessment, and the importance of proactive communication and support for young people on mental health waiting lists, particularly those who are neurodivergent.

Educational Transitions

4.28 Douglas's educational journey involved several significant transitions, each of which required tailored support. During further education, he underwent major surgery yet continued with his studies, supported by a college that understood his needs and responded flexibly. It was during this period that he received his autism diagnosis and was awarded an EHCP, which provided a legally binding, holistic package of support up to age 25. The EHCP captured Douglas's aspiration to complete his A' levels and progress to university – an ambition he achieved.

4.29 Douglas began university in 2019, with the institution proactively offering transition support, including welfare sessions and practical guidance. However, he struggled with anxiety from the outset, exacerbated by difficulties at home. Despite ongoing support and a period of deferment, he continued to find university life challenging and ultimately withdrew in 2021.

4.30 A key systemic issue emerged when Douglas started university: his EHCP ceased at the point of enrolment, and there was no formal mechanism for transferring previous assessments or support plans to the higher education provider. As a result, the university had no access to his identified needs and relied entirely on Douglas to disclose them. Although the university put in place a comprehensive support package – including wellbeing services, 1:1 sessions, and financial and study support – this lacked the statutory weight and continuity of an EHCP.

4.31 The review cannot change national legislation, but it highlights a local opportunity: where young adults with EHCPs progress to local higher education settings, and consent is given, EHCP information should be shared in advance to ensure continuity of support and avoid young people entering university “blind” to their own assessed needs.

Transition to Apprenticeship

4.32 Douglas secured an NHS Care Support apprenticeship in April 2022 however, the four-month gap before the apprenticeship began created a prolonged period of uncertainty. During this time, Douglas’s mother raised concerns about the impact of the upcoming 12-hour shifts on his health, but this information was not shared across agencies, limiting opportunities for coordinated support.

4.33 Douglas saw two different GPs during this period with concerns about excessive sweating. These consultations were treated as routine physical health issues, but they represented missed opportunities to explore his escalating anxiety, particularly given his history of depression, suicidal ideation, and social communication difficulties. Continuity of GP care – usually in place for Douglas – was disrupted at a critical moment.

4.34 Nationally, support exists for young people seeking apprenticeships and for making reasonable adjustments once they begin, but there is little provision for the interim period between securing and starting a role. For Douglas, this gap was significant. Since his death, Norfolk has introduced the Working Well Norfolk programme, offering employment-related support for people with long-term health conditions or disabilities, including help with preparing for new roles.

Key Line of Enquiry 4- Was the impact of Douglas being a carer fully explored and understood by agencies?

Douglas as a Young Carer

4.35 Douglas took on a caring role for both his sister and, at times, his mother from a young age. Although he found purpose and pride in supporting Henrietta, this responsibility placed considerable pressure on him, particularly given his own health needs and anxiety. He was identified as a young carer at age nine and initially received effective 1:1 support, which he valued greatly. However, when funding ended, this support shifted to group-based provision, which Douglas found difficult due to social and communication challenges. He eventually disengaged, and no follow-up took place.

4.36 As Douglas moved into adolescence, his caring responsibilities continued, yet agencies working with Henrietta did not raise concerns about the impact on him or consider whether he required a young carer's assessment. Despite clear statutory duties under the Care Act 2004 and the Children and Families Act 2014 to identify and assess young carers, Douglas effectively fell off the radar once he left the youth club. As a result, the emotional, developmental and practical impact of his caring role was neither understood nor explored during a crucial period of his life.

4.37 This represents a significant gap in practice and highlights the need for robust systems to identify, assess and support young carers – particularly those with additional vulnerabilities such as autism, mental health needs, or social communication difficulties.

Transition from Young to Adult Carer

4.38 By the time Douglas reached adulthood, he was no longer recognised by agencies as a young carer, and therefore no formal transition took place between young carer and adult carer services. This lack of visibility meant his caring responsibilities – and the impact on his wellbeing – were not explored or supported during a crucial developmental period.

Douglas as an Adult Carer

4.39 Agencies had inconsistent awareness of Douglas's caring role between ages 18 and 21. While GP records and correspondence with social care indicated he was providing significant support at home, there is no evidence that practitioners explored what this meant for him or what help he needed until his sister turned 18.

4.40 Douglas underwent an adult carer assessment in June 2022, shortly before his death. He rated himself highly across all domains and expressed that his main concern was support for his mother. His case was closed. At the same time, Charlie was also assessed as a carer by the same organisation.

Her assessment raised concerns about Douglas's ability to cope, but the two assessments – completed by different workers – were not triangulated. As a result, key information was missed, and Adult Social Care was not informed.

4.41 Since 2022, the voluntary carers organisation has strengthened its practice, including joint assessment processes, a preference for home-based assessments, and autism-informed training for staff. Norfolk has also invested in early identification of carers, co-produced tools, and multi-agency workstreams to improve recognition and support for both young and adult carers. Despite this progress, the review highlights the ongoing need for practitioners to understand the lived experience of carers, apply a Think Family approach, and ensure assessment outcomes are shared so that the whole household context is visible. Many carers do not recognise or disclose their role, and sensitive, proactive identification remains essential.

5 Conclusion

5.1 Douglas was a young man on the threshold of adulthood. To many professionals, he appeared happy, settled and optimistic about his future. In reality, he lived with significant anxiety and depression, often masking his distress and avoiding asking for help for fear of burdening those around him. The contrast between how he presented and how he felt was profound.

5.2 Although Douglas was known to numerous agencies – some working directly with him, many more involved with his sister – only a small number truly understood his daily lived experience and adapted their practice to meet his needs. For many others, Douglas remained largely invisible. This invisibility meant his voice was not heard, his autism was not consistently understood, and opportunities to provide support or undertake assessments were missed.

5.3 The complexity of Douglas's needs, combined with the pressures within the wider household, sits at the heart of the learning identified in this review. A consistent theme is the need for practitioners to view situations through an autism-informed lens, particularly within health services where mental health, suicide risk and waiting times intersect so sharply with autistic experience.

5.4 Many of the issues highlighted in this SAR reflect national challenges that require national solutions. However, it is important to acknowledge the significant local developments already underway in Norfolk to strengthen autism awareness, transitional safeguarding, suicide prevention and support for carers.

5.5 Douglas had hopes and ambitions – he wanted to travel, to learn, to broaden his horizons and make a difference in the world. His life was full of potential. In honouring his memory, Norfolk SAB is committed to learning from his story and driving forward improvements that ensure agencies work creatively, collaboratively and with curiosity, so that no young person remains hidden in plain sight.

6 Recommendations

This review has identified several areas of learning which the partnership should consider. The following recommendations are made to address these areas.

1. In cases where multiple family members are engaged with various services, multi-agency practitioners should collaboratively identify and assign a liaison professional based on who holds the strongest and most trusted relationship with the family and has meaningful, regular contact. This liaison role, in communication with the other agencies, should take responsibility for helping the family clarify pathways and entitlements, navigate key services and provide consistent, family-centred guidance. This role will provide valuable support to families, improve service navigation, and foster trust between families and support systems. Quality assurance activity should be undertaken within 12 months of publication to evidence the recommendation has been implemented.
2. When assessing risk professionals must consider all members of a family, including fathers and male carers. Information about family members should not be taken on face value and professionals must be professionally curious and make the time to check the accuracy of those views. This is relevant in all cases but particularly in cases that involve acrimonious parental relationships. This approach will be evidenced through NSCP multi-agency quality assurance activities and shared to the NSAB for assurance.
3. The partnership should review the appropriateness of autistic people being subject to risk assessments which are based on expressing how they are feeling. The review must be informed by an awareness of the communication difficulties that many autistic people face and their difficulty in accurately expressing their feelings. This work should include specific consideration of how suicide safety planning risk is carried out with autistic people. The NSAB should seek partnership assurance evidence from individual agencies that this review has been undertaken, and appropriate remedial action has been taken.
4. NSFT should ensure processes are in place regarding service users (particularly those who are neuro divergent) being supported and communicated with whilst they are on waiting lists and/ or part way through interventions when they need to be reallocated.
5. UEA, working with Children Services, SEND and other educational establishments (City College and Sixth Form providers), will lead on developing a local agreement to ensure where local young adults study at a local higher education establishment, EHCPs are (with the consent of the young adult) shared with the higher education provider ahead of them starting their course and there is a commitment to agreeing that the support identified within the EHCP is continued. This local agreement will be implemented within 9 months of the publication of this report. A copy of this this agreement will be shared with NSAB.

6. Practitioners should be actively seeking to identify carers using all relevant opportunities. When identified this should be flagged on young carers records and shared with relevant agencies. The success of this recommendation will be measured through a year-on-year increase in formally recognised young carers by Children Services who will provide NSAB with assurance evidence.